

MINUTES OF PEPFAR OVC PARTNER'S MEETING

ABSA Conference Centre: May 11-12, 2006

DAY ONE

1. WELCOME

Anita Sampson, USAID

- Welcomed all to the meeting.

2. GREETINGS AND INTRODUCTIONS

Dr Carleene Dei, USAID Mission Director

Gave a special thank you to the people from Department of Social Development. USAID is ultimately made up of administrators. Partners on the ground do the real work. PEPFAR is the largest international health initiative directed at a single disease, with \$15 billion over 5 years. South Africa has the highest amount of PEPFAR funding. This is good but also a large responsibility. South Africa is responsible for a quarter of the PEPFAR results. 1.5 million Children under age 15 who have lost one or both parents. Extremely urgent action is needed. PEPFAR is committed to sound planning, proven techniques, and must be in line with SAG policies. One objective under PEPFAR is to give OVC a chance to grow into healthy educated people that can contribute to society. Our programs have made substantial contribution.

This meeting is for learning and sharing. Networking is priceless. It improves efficiency. This meeting went so well last year that it has been applied to other objective areas of PEPFAR. Meetings will continue on an annual basis. Mentioned three gems relating to activities:

1. Importance of coordination
2. Need to pay attention to the role of boys and girls at different stages of development. Girls are overall more vulnerable in many ways. USAID has worked with Department of Justice in many ways to intersect programs. Gender considerations must be incorporated into projects.
3. Must nurture meaningful participation of children. We must listen to children to help programs become better. Adults do not always have all the answers.

3. PRESENTATION BY CHILDWELFARE SA

Ms. Megan Briede, National program manager

- Estimated 1 social worker per 300 children.
- Social workers tend to spend their time in courts doing legal placement of children and do not have time for actual monitoring of children
- An alternative needs to be found to translate social work into social justice
- Childwelfare SA is the National body for child welfare in the country.
- Umbrella organization with 169 member orgs.
- Serve as National spokesperson.
- Nationally coordinated programs. Have provincial offices in every province and systems provided differ on what each societies needs are.

Asibavikele – Lets protect them

- Program is child centered. Most SA programs on HIV are focused at adults. This is for children and is based on the CBC approach. Attempt to provide assistance at an early stage to children that are at risk , also making early plans before the child is orphaned
- New program has only started in July 2005
- Use collective community involvement and support due to minimal formal welfare structures in rural communities and lack of trained human resources
- Main program aspects are – HIV/AIDS specific, CBC approach, child centered, capacitating children / caregivers / community volunteers, aimed at prevention and early intervention

- Volunteers monitoring foster care (since social workers don't have the time to go back out after placement). Volunteers can inform social workers of issues before they become problems
- After six months has developed training materials, trained many representatives, and has already started reaching many children.
- Program is based on a stage model
 - Step1** Consultation and mobilization
 - Step2** Developed training materials (social workers don't have time for this)
 - Step3** Trained project teams- Childwelfare staff along with social workers from member organizations, and two volunteers
 - Step4** Training of volunteers. The whole process was very standardized
 - Step5** Implement organizational and administrative requirements within the actual organization. Also very standardized throughout the country
 - Step6** Deployment of volunteers and looking at where they are necessary and what package is necessary for the different communities.
 - Step7** M&E – Have a national steering committee – overall planning on national level,

Roles

- Project teams – coordinating and managing program at site level and fundraising
- Volunteer management committees elected that do work schedules, administration tasks and community awareness
- Do focus group discussions and take samples of volunteers to ensure sustainability of volunteers (increases retention of volunteers since feel they are taking part in policy formulation) and also learn from their experiences in order to better projects.

Lessons Learnt

- Importance of sticking to deadlines so that other areas can also be reached.
- Volunteers have been essential since the community knows them and they know people in the community. They are better qualified than a social worker to identify good families for foster care.
- Realized must build relationship with community. You cannot just go in and start operating. It takes time to build trust

Successes Include:

- Impact on children, families, volunteers and community – clearly visible
- Guidance - that it provides to the community as new projects pop-up
- Capacity Development
- Standards - it is helping set a standard so that same care is given nationwide by all service providers

Challenges include:

- Capacity - Social Workers are still overburdened with administrative responsibilities
- Building Community Trust
- Volunteer sustainability (employment main cause for lack of retention)
- Poverty and Material Needs – challenge for volunteers to focus on emotional support when there are so many more urgent physical needs

Questions

What is the volunteers' stipend?

120 Rand a month.

What things do volunteers indicate in the focus group discussions will get them to stay?

Volunteers appreciate acknowledgement and being valued by the community and the organization rather than seen as the people who perform the menial tasks. They want to be recognized as professionals and appreciate skills training

What is the task description of the volunteers?

Identify OVC, assessment of needs, and plans to deal with those needs. Volunteers do home visits and then plan with a social worker to see how best to solve the situation.

If Child Welfare is trying to identify children before they become orphaned why don't they focus on HBC?

Don't want to move out of area of specialization, so in these cases we refer to other people. Don't want different types of volunteers. Volunteers are purely to form direct link between child and social worker. Volunteers can almost be called social worker assistants.

What do Child Welfare SA volunteers do when they come across cases of abuse in home visits?

The volunteers get to know the social worker personally, so this speeds up an intervention. Volunteers are instructed to refer such cases to their social worker. Ideally it would be good to have one social worker per area dedicated to HIV/AIDS cases.

4. FAMILY HEALTH INTERNATIONAL

Ms. Mmule Rakau

The background to FAMILY HEALTH INTERNATIONAL

- FABRIC – Faith based regional initiative for OVC
- Implemented in 3 countries – SA, Namibia, Zambia
- 5 year project through USAID funding 2005-2010
- Operates in 8 provinces – not in Western Cape

General

- SACBC staff trained in M& E
- Adapted SACBC system tools so that new tools do not have to be developed
- Information flow: Goes from headquarters in Arlington the whole way to sub-recipients in provinces
- Partnering with existing FBOs
- Family centered and Children based programs

Guiding principles include:

- Provide quality OVC services by strengthening the capacity of FBO partners, strengthen or create linkages and networks to coordinate coverage
- Provide timely and reliable information and meet reporting deadlines
- Specific objectives have been outlined to increase number of OVC reached

Objectives 1: Increase number of OVC reached

- Identify sub-recipients,
- Sub-agreement development and disbursement of funds
- Training
- Ensuring reporting and quality of data is correct

Services that will be delivered:

- Food nutrition support
- Access to health support
- Education support
- PSS, access to health and social grants, Birth and ID docs.
- Bulk has been nutrition

Targets Reached To Date:

- 37% of OVC targeted
- 45% OVC caregivers trained
- 110% Sub-recipients selected
- However project is still ongoing

Objective 2: Strengthen FBO capacity

- Purpose of sub-agreements

Activities

- Determine SACBC staffing needs and hire staff
- Develop SACBC/FHI Sub-agreement
- Review and revise SACBC grant making process

- Conduct participatory organizational capacity assessment of SACBC
- Develop and implement capacity building plan
- Develop sustainability strategy

Achievements

- Three SACBC staff have been hired
- SACBC sub-agreements have been signed
- Conducted an organizational capacity assessment and areas of strength and weakness were identified. A corrective plan of action has been made
- M&E training for staff

Objective 3 & 4: Ensure performance

- Develop tools and apply a referral tool for OVC services
- Participate in different health care forums
- Link OVC organizations to government's existing social assistance
- Develop system to disseminate information
- Annual reporting to USG
- Will continue to strengthen M&E and ensure long-term sustainability by putting in place financial management systems for sub-recipients
- Focus on quality improvement and quality assurance and develop a tool that combines the both to measure quality of care

Achievements

- Referral tool for other OVC services has been developed
- OVC have been successfully linked to government social grants
- Ongoing participation in various forums

Challenges include:

- Time constraints
- Delayed work plan approvals
- Multiple sources of support at sub-recipient level
- M&E work demanded more time from the volunteers, some illiterate
- Poorly resources areas
- Geographical spread of sub-recipients
- Retention of volunteer staff
- Reporting to USG (reliant on reporting of sub-recipients)

Questions

What is FHI's view on our standards of quality of life, what changes do you want to see in the children, not in the services?

The more services that are provided, the higher the quality of life. There is an ongoing process of quality assurance. Still in the process of developing indicators - not sure on what changes they want to see in children.

General comment: Must explore what good quality means and how it can be measured. Organizations need to start focusing on changes in the OVC rather than changes in the services they provide to them

How are OVC identified?

We do not verify cause of death.

5. PRESENTATION BY HOPE WORLDWIDE AFRICA NETWORK FOR CHILDREN ORPHANED AND AT RISK (ANCHOR)

Ms. Bulelwa Tsotetsi

General

- Multi-sectoral partnership - Hope worldwide, Rotarian Fight for AIDS, Emory School of Public Health, Coca Cola

- Focus on 6 African countries
- Focus on informal settlements and RDP houses
- Promote Holistic care of OVC
- Identify key stakeholders and OVC through community mapping, and then divided into direct intervention and partner empowerment programs.
- Primary intervention is focused on emotional aspects and carried out through Kids club.
- Volunteers get to know kids and identify needs and develop relationships while they help with homework or play
- When special needs are identified, the child goes into one-on-one consulting
- If HOPE can't provide services it refers the OVC to other organizations
- Also family orientated by assistance in legal grants
- Also has some care-giving aspects and provides some training to family members
- 6 kids club and 5 support groups operating at the moment.
- Partner empowerment programs are carried out through sub-granting

Challenges include:

- Struggle for venues since working in poor communities, have to share community centers with other organizations and events
- Difficult to keep volunteers motivated and reliability
- Trouble building trust with community since other orgs haven't kept promises
- Balance between meeting urgent need and not creating dependency
- Young leadership teams in M&E need a lot of training in administrative skills and support

Questions

Please provide more information on the Kids Clubs.

These are run once a week on Saturday mornings. Children get a meal. Children tell us what they want to do at the kids club, and usually that is done – drama, sports etc. Also has life skills aspect, and also do identifying of leadership potential in kids and train them to assist.

Have you had issues of migration?

Currently only 4 months into the program, so have not encountered client movement too much

How are volunteers identified and trained?

They are identified through community stakeholders and trained using PSS manual. Exit interviews with volunteers assists in identifying new volunteers and assessing what training needs to be furthered

General Comments: Look into the possibility of linking information of all training manuals.

Response: USAID is trying to make an inventory of who is using what and when.

Specific to OVC work, is there any different way to how people volunteer their time, because all organizations are facing problems with volunteers since it is primarily a transit position between employment?

Looking at the possibility of corporations adopting Kids Clubs. This would alleviate the volunteer issues and help with sustainability issues. This would allow for the children to be observed over a longer period of time and that way see if services provided are making a change. It is a move beyond emergency response to sustained response.

General Comments: Income generating activities should be a priority in OVC work and should be specific to address community needs, there should be a move away from beads and vegetable gardens to provide a service or product that their community h (example- a bread factory in a community that has to trouble getting bread since it is remote is willing to purchase.

6. PRESENTATION BY DRAM AIDE

Professor Lynn Dalrymple, Director

General

- Use of story telling as part of psycho-social support (PSS)
- Big question - can peer educators be counselors? There is a huge spectrum of what counseling is; can there be such a thing as lay-counseling? This can be the same with PSS, is it necessary for children to go to trained professionals? Parents and friends need to start providing PSS.
- Exploring god-parenting with FBOs. Mobilize volunteer who will take interest in the well-being of the child.
- Build circles of support (started under Khomanani), closest circles made up of family, church and community members. Second circle made up of local school, local businesses and farmers, third circle made up of faraway friends that can contribute money.
- Story-telling is part of parent's care for children, so this must be part of what volunteers should do rather than just hand out food
- Also encourage children to tell their stories (good stories have come out of this as well as useful stories, specifically about abuse). Good for children as it builds self-efficacy and also good for research
- Stories are the foundation for further expression, it is then extended to drama, community radio etc.
- Use of folk stories and sacred stories and their values should also be used and even look at stories that need slight changes of values and adapt the stories
- Role of godparents and teachers is to tell stories and listen to stories, which is linked to early development.
- Must embed good cultural values while still young
- Emphasis has been put on the importance of income generating projects and many different types of projects have taken place
- Also attempting to build caring schools that give PSS through youth clubs that run the same projects in the schools

Challenges include:

- Difficult to take about other needs when basic need are not being met
- Orphans are stigmatized, so welcome discussion on how to address that
- There are currently many discussions about human rights, but tolerance is not sufficient, there needs to be a shift to respect and admiration

Questions

How do you decide what values you want to instill in the children?

We talk about the story and make a role play that examines the situation and so different values come out. For the most part we fall back on the constitution and try to instill a culture of respect and admiration for different values. Good as kids bored of regular HIV/AIDS awareness and stories are better at grabbing attention.

Has it been difficult to find or train volunteers with the skills to do this?

Have been using university students, which works very well and has allowed for much exploration and diversifications since are educated and can adapt. In terms of volunteers and community members, it has been more difficult but we have come up with a clear book with a very specific program that they go through, along with a training course for community members. This is effective but only for a short term since they can't depart at all from the training guide. There are only so many times you can repeat the same activity/story to the same audience.

7. PRESENTATION BY AFRICAN MEDICAL AND RESEARCH FOUNDATION (AMREF)

Ms. Sabrina Lee, Ms. Melusi Ndhlalambi

General

- Largest health and development organization in Africa
- Health is the entry point to help escape poverty
- AMREF Works in the most disadvantaged places in South Africa.(Presidential Rural Nodes)

- Interventions aim to empower community and allow them to define their own solutions
- All projects are run with local governments
- Strategy – Teach, Test and Tell.
- A lot of work on raising the knowledge of children rights
- Key point of organization is networking
- Support provided to drop-in centers to go beyond feeding schemes to full service providers
- Promote Community based multi-agency childcare forums
- Life-skills training for in and out of school youth
- Improving the functional integration of service providers, departments and civil society programs
- Goal is to strengthen capacity of existing structures, so most work is with current service providers to improve planning and coordination.
- Train and capacitate different organizations by bringing them in as partners
- Also provide for teachers and healthcare providers needs
- Goal is to establish long-term coordination
- Also a model was built to train and develop systems at the community level which promote the collection, tracking, and so on of OVC
- Raise awareness and understanding on OVC rights by government and civil society stakeholders along with OVC themselves
- Training of trainers
- Training and mentoring program
- Provide guidance to government
- Train lay-counselors
- Will establish local service database so that can identify and track children easier and form a referral support system between government and organizations
- Technical assistance to partners so that they have the capacity to take their projects forward
- Will engage children since so closely linked to the drop-in centers and this will provide their feedback to develop more projects

Questions

You are doing a lot of training, is your training material available?

Will have it available soon, we are in the process of getting accredited and will share it, mostly for NGO capacity building.

What about traditional leaders?

Yes, we are bringing them in, especially when it comes to gender violence and HIV/AIDS

Mentioned childcare forums, what is the focal point of those forums, usually they start well but then they drop down?

Comes back to question of volunteerism. Goal with these forums is bringing people in from all the different sectors, just to extend what they are already doing

How do you keep those forums running after the project is over?

The objective is to do mentorship so well that it will create champions in their field and in the process make organizations stakeholders.

8. PRESENTATION BY WITS PAEDIATRIC HIV CLINICS

Dr. Harry Moultrie

- Health based program in Johannesburg.
- Offers a clinic within Hani Baragwanath hospital. Try to deal beyond medical care to cover social aspects but having low success.
- The clinics are all over Johannesburg and provide medical care. The new program is an attempt to join the treatment program to OVC programs

- One of big challenges is the lack of mentorship in the healthcare system.
- How do we improve the referral system in and out of the health care system? A national pediatric network is needed to build up referral systems, avoid duplications and avoid lack of coverage
- New program is to scale-up access to ART and OVC care
- There is an equity issue within children's access to treatment between provinces that must be addressed.
- Challenges are building-up referral systems, there are good projects but they are not linked
- Myth that a doctor is necessary to provide treatment to children, must look at other options
- Must start on projects that do not avoid the issue of how OVC come to be. Prevention rather than care should become a stronger focus
- Purpose of project is to improve equity
- Looking for project partners to build collaborations
- Very new to OVC realm
- Mobile clinical support teams include a social worker that goes out to areas and provides services.
- Not a clear project yet since planning on using local knowledge. So no clear plan but there is a clear methodology to create it
- Sharing of knowledge is essential. Must compare data and learn from each other.
- Have to realize that children can be treated by nurses and don't need doctors once initial diagnosis has been made, must surpass this stigma and train nurses to be capable of treatment because there aren't enough doctors to treat every kid with HIV/AIDS
- Referral problems because OVC usually don't reach the medical care system
- Health care workers making it difficult for people to get treatment by making their own rules due to how overwhelmed they are with their workloads

Questions

What is being done to incorporate the community service to the medical service?

Problem with medicine is it more of an apprenticeship (learning only comes through doing), so it is a struggle to get people trained

How do you make this kind of care of children in the medical community a national program and raise awareness that it can be done?

Not sure, welcome a discussion.

Comment- WITS should focus on the treatment, there are plenty of other organizations that will be willing to partner with WITS to deal with OVC issues

How do you address the stigma since you have a mobile clinic specifically for AIDS that comes to a certain town every Wednesday?

Work in department of health sites, so it is not clear that it is for HIV/AIDS

Is TB being addressed in your projects?

TB in young children is very difficult to treat. Trying to find ways to manage TB better, but a real challenge.

9. PRESENTATION BY SOUTHERN AFRICA CATHOLIC BISHOPS CONFERENCE (SACBC)

Mr. Anthony Ambrose

General

- Worth mentioning that this SACBC is very different from the SACBC mentioned in the FHI presentation.

- Relationship between PEPFAR and SACBC is threefold, first part is the consortium on treatment, second is a sub-grant partnership. This grant, specifically, is a direct grant with CDC.
- AIDS program is serving 5 countries on prevention and care, OCV, and ART.
- 11 OVC sites with FHI partnership.
- Catholic Church in SA aims to provide and support basic security needs and access to education
- 2 year project
- Build-on and strengthen OVC programs at diocesan and local level
- Coverage is in 9 provinces
- SACBC has very good government cooperation due to its long history of close linkage but it largely depends from province to province. All data is reported into district health office. SACBC has worked really hard at building these government relationships.
- 3 objectives: 1) building capacity of FBO partners and Dioceses to implement within the OVC framework 2) Provide care and support services to OVC and families 3) Building and strengthening community responses through local networks and advocacy initiatives
- Several of the sites where the SACBC is operational have OVC services, majority of the OVC are HIV positive and so are put on treatment. Provide on-site services. Several already have on-site OVC treatment.
- Basically new grant covering all aspects from care to treatment under same umbrella while before treatment and other areas was funded by different agencies.

Activities

- Continuation of HBC program for OVC
- Educational support of OVC (early education programs)
- PSS for OVC
- Food and Nutrition support (vital entry point, how can you give people proper treatment without nutrition?)
- Training of caregivers, FBO leaders and families of OVC
- Advocacy and networking of services
- Social grants programs
- Mentoring of programs
- Sustainability of programs
- Prevention

Work plan

- Identify partners using existing structures
- Build capacity
- M&E – development and implementation of M&E tools

Questions

What is the service outlet, the point of contact between the project and children?

Mainly through church structures that are established in communities

Youth prevention programs, do you talk about condoms?

It is an area of prevention that is used and they do talk about it, but we also look at its double effects. Primarily, SACBC promotes the AB message.

Are there particular challenges you face?

Access, infrastructure, implementation (work plan often changes), and also level of articulation at program response. Another challenge is morality versus traditional values and how to incorporate the two. Each Diocese has a Bishop in-charge; he decides what the areas of needs are. Most funding is from the US, local contribution is very little, so little self-sustaining ability

Old mission hospitals that communities use to rely on very heavily, is there not something to learn about how those use to operate? What kind of models did they have?

They ended long ago due to the lack of capacity, lack of funding, the lack of people to work in these areas, and government taking over ART processes.

10. PRESENTATION BY AFRICARE

Ms. Joan Littlefield

General

- Injongo Yehtu – project name meaning “our vision”
- Almost exclusively PEPFAR funded
- Linked to different Eastern Cape departments, since project is about rolling out their programs
- Working in very rural area
- ARV roll-out support
- Improving HBC and CBC support
- Many community based activities for prevention and stigma reduction
- Livelihood and nutrition – vegetable gardens
- Large OVC component
- Working with traditional healer and training them, very successful as it has even caused them to go for testing on their own. They are becoming more aware and spreading the prevention message.
- Target out-of-school youths, in-school-youths, ages 10-13 and mothers for nutrition
- OVC component is the same as what everyone else is doing – help department of social development, only 3 social workers in huge geographic area and 8,000 people. Help them with volunteers to identify OVC and also helping with databases
- Must take dynamics of each community into play and allow them to come up with their own solutions for managing how they will deal with OVC
- Giving access to health care. Under-2 youth are in deep trouble and on decline; volunteers should help with basic health needs of these kids.
- Looking for income generating activities for girls, so welcome any ideas. But it must be appealing to young girls (not vegetable gardens).
- Will expand past household level volunteers
- Gardens are not best way of cash source income but it is good to boost moral, and helps develop comradery

Questions

That specific area had one of the most funded agriculture infrastructure systems, huge potential for commercial agriculture.

Africare has a long history of agriculture and EU is working on a couple of projects with us.

How do you respond when you find that a child is not growing?

Use public sector services - teaching nurses and having a nutrition coordinator step in and do counseling. Our job is not to provide the direct services but rather to link beneficiaries to these activities. Also part of public sector response is to provide food supplements. There is a need to see better functioning of the system before we add new approaches – nurses are not even ordering the food supplements that they should have stocked. These kinds of aspects must be remedied before new elements are incorporated

What about sustainability?

For income generating there is a need to do business assessments and go outside the typical. Look at projects such as producing bricks. Projects need to be viable – need to do a situation analysis and identify a need the project can meet.

How do you deal with the challenges of your traditional healers?

Biggest challenge with them is their moods. Actually no major problems, they have been a joy and so that is why we are training more. Many of them have become treatment supporters. We don't push them away and they are very happy to merge the medical models. The role of healers has been restructured because if not people get tired of hearing the same message from them over and over, now they are playing the role of facilitators more often.

11. PRESENTATION BY WORLD VISION

Ms. Daleen Raubenheimer

General

- Project name, " Networks of Hope"
- It is about building networks, and so building capacity of every HIV/AIDS NGO
- Child focused organization in over 100 countries
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- Committed to an area development program for a minimum of 15 years. Within this area focus on many projects that all have same overarching aim to reduce poverty.
- Operational in 6 of 9 provinces
- Money has gone to anything that can influence the quality of life of a child. World Vision has even taken part in building and infrastructure when it appears to be helpful. Service delivery differs in all areas since communities determine their own needs and priorities.
- Challenge is how to ensure definition use is standardized for direct and indirect beneficiaries
- Funding from PEPFAR is a match to what World Vision is putting in, in that specific area.
- already supporting about over 35,000 children in SA and 350,000 in Africa
- targets disaggregated by gender
- Difficulties in ensuring double counting does not occur
- Key activities: basic packages of care, key documentation, facilitate access to nutrition,
- Severe need for communication between organizations. Role and function of world Vision is to strengthen them
- Currently busy with research program on stipends versus benefits for volunteers
- Finalizing a Muslim version of training material
- Spin-offs based on needs of community

Questions

No questions

12. PRESENTATION BY WITS PAEDIATRIC HIV CLINICS

Dr. Tamy Meyers

General

- Project focus is care and treatment for children and medical management of HIV/AIDS in children
- Presentation is more just to inform on what is available and what should be available, basically give the other organizations a bit of awareness.
- How do you measure how successful you are? In the medical program it is much easier.
- Health care is part of the basic need of children
- The oldest child in the clinic is 19 (matriculated with 3 distinctions). This shows the high quality of health and life that is available and can be achieved through proper treatment.
- A third of the women attending ANC are HIV positive
- It is estimated that between 250,000 and 400,000 children are infected
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- PMTCT – it is preventable condition in children, without any intervention 30% will transmit
- Current program recommends Nevirapine, it reduces transmission rate to 15%. Most transmissions occur before birth.

- What should be available in SA? A program that includes VCT at ANC. Women are currently counseled and then asked if they want to be tested, less than 50% get tested. Others do it in reverse and test unless otherwise specified. This has helped put the percentages up. Women should get a CD4 immediately; it also helps decrease transmission to the child. This is not happening in SA and it can.
- Breast feeding can cause HIV transmission, so there is a need to give training and counseling to teach mothers not to mix-feed and use Nevirapine together.
- There is a need to identify children that are HIV infected.
- Complications occur with children, the problem is the ELISA test is testing antibodies and mothers' antibodies can last 18 months in a child, so the child may test positive as a result of the mother's antibodies not because the child has the virus. SAG currently does not offer PCR testing which is a more accurate way of testing children.
- Only 20% of babies are being diagnosed early. Many die from pneumonia in 3-6 months. So if a baby is exposed it should have access to Bactrim. Stock counts of Bactrim are there, this is one of the main things that we could do along with early diagnosis to relieve the situation.
- Once diagnosis has been made children must be staged clinically (look for physical signs) and immunologically (CD4 count). Then we can determine which needs treatment
- This WHO staging system should be used to determine if a child needs ARV treatment.
- From age 6-up you can use CD4 count, before that one must look at the CD4 percentage
- For medical treatment it is necessary to have an identifiable caregiver, so this raises concern because the most vulnerable will get discriminated because they don't have parents. For this reason, WITS must work with other organizations and also develop a system of treatment buddies with children just like with adults. Regular check ups must also be ensured
- Older children go to TB clinic, get treated and are never tested for HIV. They should be tested since there is such a clear link, as the child gets older treatment becomes more complicated
- TB and ARV treatment shouldn't be put together, preferable if a child is on TB treatment that should be finished first and then go on to ARV.
- Children do very well on ARV treatment. Nothing restores hope as much as seeing children rebound on those regimens. Clearly ARV has huge social implications
- Problem is caregivers are usually going home with big bags of treatments. Easier solutions need to be explored from within the medical society.
- Access to refrigeration for medicine is also necessary. But there are alternatives, like teaching parents to open capsules and dissolve medicine. We must try to work around problems.
- Adherence is vital. Over 95% adherence is required for success; this means the PLWHA must take medicine 2 times a day for the rest of their lives. If not the virus can become resistant to the drugs
- WITS has started children on ARVs, before the actual pilot program, with some children's' homes being able to access funds for treatment. This has made a huge difference
- Some say that when the disease gets really bad we shouldn't waste resources providing treatment. From personal experience, Tammy has seen kids from near death come back to health. We should find excuses to treat rather than not to treat.

Questions

What are the effects of treatment on lifespan?

In South Africa there is only short-term experience with treatment but it is estimated that it can increase a child's life by 12 to 15 years. This will still allow us to at least get to the next step and buy us some time. Fight to normalize HIV AIDS as a disease because there is treatment and ways to make life better but can't do much if nobody knows.

Are hospitals rolling out, do you just walk into a clinic, how does the whole treatment process work?

There are many VCT sites, so you can walk into a clinic and if they don't give treatment, they can certainly refer you. TAC provides a list of providers on the internet or also through the AIDS HELPLINE. The main problems are waiting lists. There is at least one ARV site in every district. Go to district level hospitals.

How do you provide medication?

WITS was able to get the pharmacy to give medicine out for 2 months at a time. One should be able to get medicine for 3 months or 6 months if your condition has stabilized, especially because of transport difficulties, but one must also take into account that check ups are necessary. Also one should be able to get medicine from sources other than doctors if stable. Pediatric care should not be seen as any different from adult care

For ARV and general medicine for children, a lot of groups struggle when they don't know who the legal guardian is? What does the law say, and how do you get around it?

A new law changing the definition of caregivers is about to be enacted. Hopefully volunteers can be recognized as legal guardians. When in dire need one must look at the constitution, and the constitution clearly states that one should do what is in the interest of the child.

Are Children being brought in for prophylaxis after rape?

There is a separate facility for that in the hospital

13. Day 1 wrap – up

Anita Sampson, USAID

DAY 2

14. Welcome

Anita Sampson, USAID

- Gave some time for discussions on how to get children into treatment

Comments: From the age of 12 the child does not need parents' permission for contraception, etc.

However if it is a medical procedure the child must be age 14. Also if under 12, the person who takes care of the child can make that decision. New legislation is making a distinction between custody and guardianship. Ideally, now NGOs and OVC will no longer be hindered by having to go through different channels. Children's Institute has presented a paper with all the different tables that explain the subject further. However, all this doesn't have any legal standing probably until around 2008 when it is expected to be passed into law.

15. Using the Peer Education Model for OVC Interventions

Barbara Michel & Charles Deutsch

General

- Presentation is focused on peer education and the ways to use it for OVC
- Still very much developing whole concept of peer education (PE), so still on developmental stage
- Plan is to develop a national system of peer education, making a regional academic sector that will serve for prevention and also for OVC
- In 2000, rigorous high-end PE started according to a national plan
- Very few people in this country have actually seen what it can do, most education in SA still done in the front of the class room
- A lot of PE programs do take place but they are not useful because the outcomes are not measured. So there is a need to take a step further and get information to see what difference is being made.
- 4 principles roles of PE in Prevention: education, recognition and referral, informal influences, and advocacy
- What peer education is not :
 - A replacement for professional intervention
 - Whatever youth say it is
 - Awareness events and health fairs

- Energy and style with no content or rigor
 - Model youths preaching adult messages
 - "What I did when I was your age"
 - Programs designed for peer educators' benefit
 - 80% training peer educators and 20% in the actual work with the learners
- PE is a rigorous supervised subject, and not just training and then going out, must stay under training and supervision for a long time,
- Also must ensure that they are professionally deployed
- Trying to build sustained relationship beyond awareness through peer educators , youth and media , etc
- Advantages:
 - Youth learn more readily from peers
 - Multiplier effect
 - Role models BUT with shared experiences
 - Peer educators are receptive to learner-centered training, even more than professionals because they are new to the whole subject
 - Positioned and prepared to recognize and refer learners in need
 - More appealing to diverse learners
 - Flexible delivery system, not just within the classroom boundaries (can work on weekends, evenings, and various settings)
- Essential tools for PE programs:
 - Planning
 - Mobilizing
 - Supervisor Infrastructure
 - Linkages
 - Curriculum
 - Peer educator infrastructure
 - Management
 - Recognition/reward
 - Evaluation
 - Sustainability
- In the next couple of months new training manual will be coming out. They are more guidelines and one can't take them and run with them, they require some technical assistance, they are NOT a curriculum, the idea was to be adaptable to different projects. It is almost project management manual specific to peer education
- PE can be used in a variety of different setting ranging from schools to faith based settings to sports and recreational activities
- Access is of prime importance (sport and recreational activities have enormous potential)
- Goal is to have trained cadre that can work in any of these setting so that they get the message in different ways
- Prevention is also a way to find children that need help and way to find areas that are going to need attention in terms of treatment or care. There is huge gap between prevention and care and we must look at how closing it will help
- Good prevention work helps identify OVC and get them the help they need
- PE can help even when children have not identified themselves yet
- Prevention is referral resource to get OVC to you
- It also helps stigma get reduced
- Prevention cannot be lets just work with the people that show up, must have structures so that it reaches all and they are forced to hear it. Must get everyone in the room, venues to get kids in the room in a systematic and non stigmatized way
- What do OVC need? Same needs as all other children, just more. PE can meet a lot of these needs
- PE can be a proactive form of prevention that creates exposure and opportunities for helping
- Preferable to do group work because it normalizes the condition

- PE needs to be used in a more structured way to gain something from the intervention. Must have specific goal and ways to measure things against that goal
- Envision having kids, once a week for about 12 weeks with structured learning objectives but getting children to express emotions that can be helpful
- In education who do you want to be clever? Want the learners to feel smart, want them to ask questions, and want them to speak and have something to say. That is one of the best ways of measuring how successful the program is
- The goal is to eventually have groups of 10-12 kids working with each other with very little adult supervision
- One of main goals should be helping them to stay in school
- Many peer educators will have to be OVC themselves, this will also offer them a stepping stone into a career, have personal experience the talented ones can go a long way
- Many kids are not being recognized, and they don't even understand the condition they are in. Helping them understand what they are going through will make a huge difference for bringing the situations out in the open.
- Don't use PE if you are not going to be methodological and systematic about it

Questions

HOPE Worldwide runs kids clubs, what incentives do you use to keep peer educators reliable and interested?

Some institutions have started to pay peer educators; this is a very contentious issue because it is difficult to measure output and success. Some programs have an evening with pizza, and that is enough of an incentive. Some programs have an annual award ceremony. Recognition is very important but it can't be phony, only the truly good must be recognized. Creativity is the key. One must also give incentives so that the participants have a cover with their peers for why they are coming. For example they can say "we are just coming for the ice cream". Great, it doesn't matter what they say or why they are coming as long as they come

What age groups do you use and must they be the same age?

Peer educators must be a couple of year older so the participants look up to them. And this isn't sufficient, a huge amount of time must be invested, it is not easy. The peer educators must understand their own situation before they can understand how to help others. Peer educators must go through some dry runs to see that they know how to handle a group situation. The key is them being able to talk about their own experiences, that is the first step.

If you want PE to be available to a whole school, how do you address the environment so that there is no stigma, or do you keep OVC separate?

The Concept of PE is not to add stigma, so it depends on the setting. In school your public is the whole school so the program wouldn't be OVC specific. This type of program is also good as it helps create a compassionate environment for students to understand what others are going through. It would have to be completely different curriculums for OVC specific groups and school groups but prevention message should reach everybody

With younger kids 6-8, what would you recommend? Still peer led?

Absolutely, still peer led but the educators can't be that young. 16 year-olds that are still seen as "peers" can be used. The fun part of this is how to address the issues indirectly. You can't ask 'who protects you?' One must try and find different ways and indirect approaches.

Are your manuals available?

We don't want to simply distribute them like pamphlets, people must be trained, and if we know they are going to be put to good use then we provide them through the department of health, free of charge

16. A Family Centered Approach to ARV Treatment

Dr. Lewis Ndhlovu

General

- This presentation will use what we know to brainstorm and help each other
- Results from a pediatric study:
 - In the roll-out of ARVs priority was given to adults because they have a voice, only later did people think of children, this led to studies to find out what is going on for the children, and also recommendations
 - A study in June 2005, consisted of visiting several sites and administering interviews with different actors
 - 75% of caregivers said at least 1 other person in the household was infected with HIV besides the child.
 - Of the group that was infected about 52% were on ARVs
 - We also saw some issues of stigma since some family member don't know of children's HIV status
 - Caring for children is done by mother and grandmother for most part.
 - There is space for improvement in the family's role with the children
 - 45% of children received a test because they were already chronically ill
- So what we see is that they are coming in when they are already sick. Question is how can we get them in before that?

The Current Model of Care

- The pediatric HIV and ARV services are 'doctor driven' especially for children younger than 6 years of age.
- The minimum team composition consisted of a pediatrician, nurse and pharmacist.
- The maximum team composition consisted of doctors, pediatricians, a clinical nurse, a nursing assistant, a phlebotomy nurse, a pharmacist, a pharmacist's assistant, counselors, a social worker and a dietician.
- Few 'children-friendly' environments have started at health facilities
- Expansion of services will have to go beyond being "doctor driven"
- Many children are not referred because the community does not know about support systems

Family Centered Approach

- Question is what entry points do we have, how can we expand treatment? Data and literature in other countries point to The Family Centered Approach (FCA)
- Why FCA? Because it goes well with modern trends, the nature of HIV AIDS requires continuity and more than one caregiver, there is evidence that shows improved outcomes in children and families PSS and physical needs, increases knowledge and awareness, and blends well with the concept of extended families and the HBC approach
- Out of the study and the evidence elements were developed of what a FCA program should include to be successful:
 - Provider Training to Promote FCA
 - Family Information, Education and Communication
 - VCT & Treatment Referral
 - Community Links and Referral
 - Family Appointment Date
 - Emotional Support for Providers

Issues and question to keep in mind when designing an FCA

- What families should participate in FCA (stigma, disclosure of status issues)
- What are the educational needs of the families and service providers?
- What are the psychological needs of care for the child & family members
- Can family group counselling be considered?
- What links can be built between the family and the social capital in the community?
- Service organisation in primary health care versus tertiary institution setting

Questions

Was the issue of IMCI, Integrated Management, ever integrated into this research?

Yes it was integrated

90% of children are being tested after they are already sick? There are no campaigns for VCT for children, should we start on this?

There are PEPFAR partners working with government on looking at methodologies for testing that provide for diagnosis in children. Social workers and health workers are reluctant to test children. However we are still along ways away from achieving this

How well are ART programs linking with PMCT?

ART and PMCT programs are not very linked. The government hasn't moved into that direction, however some NGOs that are working on this. McCord has a very good policy. The problem is we must work within government policy and government policy has not yet formed a linked. Most children who are vulnerable are those whose parents did not enter into PMCT. We must find some way to capture that group

There is too much pressure on female caretakers we must also engage males

Yes, certainly the idea is to bring the male in. Although primary services are provided by the mother expansion would be good.

How are we supporting the volunteers with their psychosocial needs so that they don't burn out and become affected?

This must be emphasized. We often tend to forget that the service providers need the same services.

What are the legal rights in terms of testing a child?

This was already answered at the beginning of the day. When the new bill comes into effect the main caregiver will be able to give consent. Right now social workers must ask permission from the commission of child safety and submit a report with reasons before they even starts care-giving. Also heads of hospitals and doctors can seek whatever permission is necessary to give treatment

If you can't wait is there another route to get testing?

The important thing is that one must have a valid reason and keep a record documenting reason if it was done out of dire need without going through proper channels

15. Department of Social Development (DSD)

1. OVC Policy and its Implementation National Plan of Action

Dr. Connie Kganakga

2. OVC Conference

Dr. Johanna de Beer

1. OVC Policy and its Implementation National Plan of Action

- National Plan of Action has been informed through many different organizations and departments to help build a framework
- The consultative process that about a year
- Policy is based on six key strategic areas
 - Strategy 1: strengthen family capacity to respond to OVC. How do we begin to strengthen implementation to make sure that this strategy is achieved?
 - Strategy 2: Mobilize and strengthen community-based responses for care, support and protection of OVC. Government has put most of its effort on communities, because of the lack of capacity by local government but the goal is still to incorporate them slowly. A primary concerns is ensuring that there are database and that they are coordinated at the local level

- Strategy 3: Ensure that legislation, policy, strategies and programs are in place to protect the most vulnerable children. This has been encouraged by the fact that NGOs have taken it upon themselves to ensure they know about policies that are in the process of being passed. A lot of problems in this area are being rectified by engaging local municipalities. The DSD has recently finalized a curriculum for psycho-social development
- Strategy 4: Ensure access of OVC to essential services. This should include ARVs as well as housing. Access to services must include everything children need.
- Strategy 5: Raise awareness and advocate for the creation of a supportive environment for OVC. It has become apparent that communication structures are not good. Most stakeholders are not even aware of the OVC strategy. There must be a stronger move from simple awareness to actually advocating their plight.
- Strategy 6: Engage civil society sector and the business community to play an active role in supporting the plight of OVC. This country has a strong business sector that must start taking on their role in helping the children of this country. The DSD has started engaging them but there is still a lot of work to do.
- Dep of social development is secretariat for NACCA which has the national level, provincial level, and local level. Coordination - Don't encourage new structures but improve structures to work better. Problem is currently that district AIDS committees have limited capacity.
- Target OVC population most in need is 1,765,167 (the DSD is not saying this is all OVC, but it is a realistic view of what we can be achieved in 3 years). This number was established through research looking at the poorest of the poor.
- For the purpose of costing a scale of orphans was used: 0.75 for paternal orphans because most children in this country do not know their fathers. Dual, maternal and new orphans count as 1.0 on the scale.
- Coordination must also occur between the departments (An example is the Department of Education already having a nutrition program).
- Total costs were very low. This is explained because no other country in Africa has a social security system like SA. The costing has excluded social grants that are already taking care of a lot of the needs.

2. OVC Conference

- DSD is planning to have a conference primarily for strengthening coordination, July 12-15th of July.
- The Conference will take place in Sun City purely because of the discounted price it offered.
- It is planned for about 500 delegates, including delegates from SADC countries
- The goal is to help document best practices across Africa and also market the DSD
- The conference will consist of four tracks:
 - Psychosocial support
 - Policy and Legislation
 - Models of Support
 - Partnerships and Coordination
- The hope is to exchange lessons learnt, challenges, and look at ways forward
- There was a previous conference in 2003, and the DSD is looking at what the advances have been since then

- The DSD is also looking at the possibility of children participating in the conference. This looks a bit difficult, but there will definitely be a pre-workshop with children in order to see what can be taken from them to the conference.
- The DSD stressed the importance of coordinating all forums.

Questions

Is it not possible for the DSD to call for a meeting, we would love to hear what its plans are, etc?

This is a possibility but it would have to take place after the conference. We should also think about topic focused conferences, rather than organization focused conferences.

What are your strategies for corporate involvement?

About 4 businesses approached the minister and we have started to engage them. We have realized that NGOs are working with government, so corporations are now being included in several committees

We would like involvement with the Department of Labor and Agriculture, they don't come to us, we don't know how to go to them, what is the proper way to interact with those departments? What are the rules and how do we start?

It is up to NACCA, a lot of times they don't understand that they are part of the whole process; they are just starting to see their role. The Department of Agriculture has admitted it has a role to play and through task teams we will strengthen that. For NGOs, if you want to be part of whole national coordination program please come to the DSD because it is possible to incorporate NGOs into task teams

One of the main challenges is incentives for volunteers - , what is in the pipeline of the Department for providing for caregivers?

Government has started several expanded public works programs to build skills. The best option is to help volunteers become part of the program so that they can benefit from it.

What is the minimum stipend?

In terms of EPW the alignment is R1, 000 but must coordinate

Global Fund 06' has just come out. Is DSD putting proposals in?

Yes we have been trying to get support from them for years; we are going to try again this year.

Further comment: World Vision offered the department technical support to write a proposal

The Department's presentations and plans are good, but implementation is still poor, what strategies does the Department have to actually implement? Especially since people lower down in Department don't have knowledge of documents. This is quite worrying.

The Department is going province to province and becoming more practical rather than simply a knowledge base. People must be reached so that they know their rights and go and demand service. The Department is trying but it is an uphill battle

Should research be done to identify blockages and what is not currently working? We need to conduct research into where coordination has been practical and its benefits.

DSD - Don't think we need research we know where blockages are - we know where the problems are. DSD does have a sense of the number of children that are being referred and not accessing services, aware of backlog and know how much it is

16. Mapping

Mr. Gregg Ravenscroft & Alex Reid, Khulisa Management Services

General

- The presentation is on GIS mapping uses and how it can help linkages, program planning, M&E (double counting), and coordination

- Took information from last year and have produced a database and maps that organizations can access and also update. Please make use of it and keep it updated. It is not useful if it is not updated
- The system consists of a fairly simple fairly process:
 - An excel spreadsheet indicate all sites with stars serving as references
 - The GIS is a Geographic Information system
 - It Creates maps from data format, and can display data in many ways as per requirement
 - It can also link tables to points and when one clicks on a site then tables with data comes up
- General Characteristics
 - Display geographic information
 - Link descriptive data to spatial location
 - Analyze Data
 - Create presentations using maps, charts, images and tables.
- The sites are placed based on spatial information, whether it be a street, a town, or an intersection
- A problem can occur if one state the site location as Johannesburg as this can be anywhere within a large area. The best type of data would be with a GPS that gives exact location. If this is not possible, then a street intersection or clinic would also be good.
- GIS mapping uses decimal degrees on a plane to tell you how far south/north and west/east. This is same as coordinates
- Activity managers should have access to GPS units, USAID also has some that can be borrowed to get information
- Various tables with information are put into the maps
- Maps built on layers and can show different layers according to requirements
- One can look at the data according to categories (data with parameters ex- Natal, and only treatment sites). This can be useful for finding how many sites are around a certain area (ex – enter Durban and put a radius of 10 miles and gives you all sites within 10 miles)
- Data is not only for our projects, it can also tap into national databases and have lists of hospitals and so on, in order to see what infrastructure already exists in a set area
- The maps can also serve to pull up information. One can click on a district and see all sites in those districts and then pull up a table for those sites
- GIS mapping can also show demographics like population density, and then one can use that to query

Questions

This has the potential for tracking every OVC in the country, but it raises many issues, protection-wise, so what about access to this information?

The program only allows certain people to use it, at the moment works on request basis via email basis but later will potentially be able to do queries on-line. Any information with reference to a service can be captured but it can be protected and it is not available to the public

Further comment: Africa Center has mapped every single household; it is a very powerful tool, but also faces problems of access to information

Apparently there are different formats that are not compatible; what format is best and what is most used?

There are several types of files but there are also converters, these are available at the data warehouse website which provides free software compatible with the leading geomappers.

Comment: When new partners come on, they should be aware of things going on, a lot of times organizations start OVC program right next to each other. This GIS mapping could be used to go through a screening and see how many sites are in a specific area to prevent collisions. Hopefully this can be used with the EU, or Global Fund, etc.

Comment: Maybe we should circulate a piece of paper to look at the kinds of thing each organization would look for using the GIS mapping (police, hospitals, etc.) That way Khulisa knows what information we need and what databases must be tapped into.

Is there some way of shading certain things so only some have access, maybe households should be shaded and only show the servicing organization's main center in the area. There are also households that do not want to be serviced anymore, can we show that?

Yes we can do anything with it if we have the data, so the program is only as strong as the data. There are also plans to incorporate this with the PEPFAR indicators (ex look only at data where an organization has reached more than a hundred people). So the data is not just location based.

When will this be available?

In the near future, we can do searches right now but takes up too much time, and you would have to email us what you are looking for. The goal is for each person to be able to conduct their own searches. If you do email us please make sure to properly identify yourself because the integrity of the data is crucial along with its confidentiality.

Does it cover areas beyond South Africa (ex. Lesotho or Swaziland)?

No, at the moment it is just South Africa.

Comment: If the organizations are willing to invest the time in the system it will benefit them in the long run. Perhaps it could also be helpful to create a systematic plan for updating to ensure that data is always relevant and that it doesn't overlap between reporting periods

Comment: The value of this lies way beyond PEPFAR, we must look at making this available beyond PEPFAR partners and even linking it to information in the Department of Health

17. Update on OVC Guidance

Ms. Colette Bottini, OGAC Representative

- OGAC will provide the full OVC guidance in the next month
- The guidance is not finalized, this is just a sneak preview, and it is not going to answer all the questions
- This year has placed an emphasis on quality
- Definitions of OVC (strictly within PEPFAR)- Child 0-17; Orphan; Vulnerable (look at presentation and summarize)
- Some of the data available for 2005 - funding \$62 million, 1.2 million OVC reached (52% female)
- Program planning guidance – Important to address child development issues through age-specific child focused programming
- Guiding principles –
 - Focus on Best Interests of the Child
 - Prioritize Family/Household Care
 - Supporting Communities
 - Nurture Meaningful Child Participation
 - Target Gender Disparities
 - Respond to Country Context/Support Government Capacity
 - Strengthen Networks and Systems
 - Linkages between HIV/AIDS Prevention, Care and Treatment programs
- US guidance still uses global framework. for guidance, nothing out of the ordinary
- Core program areas – ensure core services are available (although differs on country to country basis), menu of services should be based on mapping, the idea is not that every organization should provide all services but rather to link

- Food and Nutritional Support
 - Shelter and Care
 - Protection
 - Health Care Services includes general health needs of OVC (including HIV/AIDS prevention) and health care for HIV positive children
 - Psychosocial Support – not just for OVC but also for caregivers
 - Education and Vocational Training
 - Economic Opportunity/Strengthening
- Reporting Issues – direct and indirect targets and double counting; In the guidance this section acknowledges some of the things that are unique to OVC, but also addressed on a country basis, so consult country teams
 - Challenges
 - Focus of PEPFAR on children affected by AIDS; need to leverage complementary resources from other sectors to address broader needs of local communities
 - Most vulnerable are hardest to reach: children caring for sick parents, street children
 - Address orphaned and vulnerable adolescents and involve them in finding solutions to their unique needs
 - Attention to gender equity in service provision
 - Maintain quality as we scale-up, establish standards for service delivery
 - Improve measurement: refine “child served” indicator, measure improved well-being of beneficiaries
 - Devolve resources to local communities and strengthen capacity of local-level partners
 - Coordinate OVC services across agencies and sectors
 - More coordination—across USG partners, with host governments, with other donors and partners
 - Retention to voluntary staff also a critical challenge
 - This was a preview of the basic outline; the plan is that it will be finalized before the annual PEPFAR meeting in Durban next month. For the most part there is nothing out of the ordinary

Questions

How do we use community definitions of vulnerability?

The community definition of who is the most vulnerable is the most important, that is the identification. Our definition is for standardizing indicators being that the definition of OVC may change from Gauteng to Natal, so need reporting guidance for when there is this difference.

Want to make sure definition is in line with SAG definitions, Anita and Annie Latour will work with partners on this issue.

Points made included:

- Definition of vulnerability is based on community, should not be based on things like education?
- Also must recognize that not all orphans are vulnerable
- Must keep in mind that we shouldn't get so caught up in rules and regulations that we leave out the child?

What the policies on treatment in terms of OVC in the guidance?

It discusses the link with palliative care, but there is separate guidance for palliative care. Palliative care guidelines are on the OGAC website

Do we want a standardized definition?

Must remember that PEPFAR is in many different countries, so it is trying to standardize and provide some guidance shouldn't be wrapped up in it, OGAC guidance is there just to fill in gaps between differences, and it is more for countries that don't have as much development in this area like SA.

Must find innovative way to count services provided

Also problem with western style of counting family because only counts OVC when should also count service provider

18. M&E – OVC Indicators

Ms. Annie LaTour

General

- Huge improvement over the last two years in data systems. There has really been quality data
- Just finished a PEPFAR audit, and there is still a little bit of a disconnect: There is a difference between M&E at the program level and at the PEPFAR level
- PEPFAR reporting requires only 2 or 3 indicators, which is not enough to run a program

Monitoring at the Program Level

- Make M&E your own
- Use for program management
- Have dedicated staff and defined responsibilities
- Ongoing training on M&E forms and definitions
- Budget for M&E (5-10% is about what M&E budget should be)
- Operationalize definitions – the definitions are very broad and you should make them into your own, but always document this
- Document the Process and make it Routine

Monitoring at the PEPFAR level

- Report the number of OVC served by an OVC program (by gender), almost like patient tracking system, actually looking at the child level rather than looking at service. Must be reached with at least 3 services to count
- Only count children that are actually being served
- Optional indicators with 8 essential services
- Also indirect number
- Number of OVC visits – optional indicator
- OVC resources are available on the website and in the SA strategic Information manual
- Why do we collect this data? The information is used to follow the progress, and send the information to Washington. South Africa is the largest recipient of PEPFAR probably because we can show with data that we are reaching substantial amounts
- Semi-annual report due mid October
- Data collection starts over in October, so organizations can count OVC again as of then, the clock starts over.
- Working closer with DSD, not recording only PEPFAR services, can we record all data for the sake of DSD? Could be valuable tool to use as can separate by districts province etc
- Disconnect between COP process and reporting process look at graph, doesn't matter when money comes reporting at certain period
- 2005 went down a little bit in terms of resources but probably because better data quality coming in
- According to the data there are still high targets to reach by September
- Double counting – may seem like PEPFAR doesn't want you to work together but that's not really the case, please work together. The Free State is special area of concern. Just make sure to let USAID know so they don't double count
- If anybody wants material for week long training this is available on the website
- The next M&E training will take place the 2nd week of August
- The University of Pretoria has a master program on M&E which requires internships. USAID has started using these interns very successfully, let USAID know if you are interested in taking on an intern

Evaluation

- There is a global PEPFAR targeted evaluation, but not in South Africa. However, USAID is going to try to buy into that to be able to compare models
- DSD OVC research task force (conducting targeted evaluations)
- Other topics that are hard to do through routine monitoring:
 - Quality of Life for OVC
 - Linkages between OVC, ARV and PMTCT programs
 - Stipends

Questions

What would be the process in a targeted evaluation? How do you go about a targeted evaluation?

It really needs to be independently done, so there is a need to hire a contractor, and on a small level it should be relatively cheap. Specific recommendations of what organizations and contractors do evaluations can be given by USAID

Clarify indirect, when you are working with other partners in a mentoring type of relationship?

An Indirect is child being reached with less than 3 services. You don't need to be providing all 3 but it needs to be getting those 3 through referrals or making sure he/she gets connected up with right providers

Referrals

Want to make sure that they are actually reached, referrals don't always carry through, want to count those that actually receive services rather than just referrals.

Do all the mobilizing activities count as purely indirect?

Will talk on a one-on-one basis to figure out how to represent those situations

There are areas of overlap?

There are plans to use a coefficient, which would require doing a once-off stop and check and then using that percentage for the next 2 years. This is especially relevant in Free State

19. COP Planning

Ms. Marie McLeod, USAID

- Large document, very large program, many different countries, targets are in the millions, SA is the highest in all, many partners and types, we work in all program areas
- What is COP?
 - The COP is a key planning tool for the USG team describing our planned partners and projects, and explaining how each element fits in to an overall strategy.
 - The COP is an essential element in our dialogue with the South African Government to assure our activities complement and support their goals and strategy.
- What do we do with COP? In Mexico the COP is used entirely. COP is same, everybody uses it for something, it is a good search tool
 - Throughout the year, USG agencies in South Africa, the US Embassy and the Office of the Global AIDS Coordinator uses information from the COP to report to Washington, to provide information to the press and collaborating agencies, and to identify opportunities for collaborations among partners
- What info do we want? This is subject to change but for the most part it is very general information
 - Sub-Partners
 - Sub-Partner Name
 - Sub-Partner Amount (\$)
 - Sub-Partner Type
 - Sub-Partner Contact Information

- Sub-Partner Program Areas
 - Partnerships with other PEPFAR partners
 - Site Data for prime and sub-partner sites
 - Partner or Sub Partner Name
 - Site Name
 - Address
 - Program Area
 - Program Area Planning Tables
 - *Prevention*: PMTCT, AB, Blood Safety, Injection Safety, Other Prevention
 - *Care*: Basic Health Care and Support, TB/HIV, OVC, Counseling and Testing
 - *Treatment*: ARV Drugs, ARV Services
 - Laboratory Infrastructure, Strategic Information, Systems Policy Analysis and Systems Strengthening
 - Narrative: Summary of activity, background on the project and organization, activities and expected results
 - Tables: Emphasis Areas, Issues of US Legislative Interest, Coverage Areas, Target Populations
 - Targets: Direct and Indirect, and explanations
- Timeframe –
 - started on COP in January
 - Ongoing APS and partner evaluations
 - OGAC expected to send guidance on may 19th
 - Between June and July 15 negotiation process at secretariat
 - July 24 August 9th, partner meetings (come with completed COPs)
 - The COP is due the 9th of August because we need to do a lot with them, all sorts of people need to read it and review it, enter new partners into database, changes to strategy notify OGAC, input COPRS only one person can enter that data into secretariat
 - So it is not unreasonable to ask for data so early being that everything must be done by September 30th
- Look at website for updates to calendar pepfar.pretoria.usembassy.gov

Questions

Are track ones included in COP and reach for SA?

Yes

Does the COP serve as a work plan for track 1?

No, the problem is that the work plans are very detailed; the COP is just a page. Left over of track ones but will not ask for that again. Track one work plans are detailed while COP is general summary.

The guidelines only arrive 2 weeks before the deadline, isn't that too little time? Do you think the guidelines are going to be very different? Can't we start the COP now?

We are not expecting many changes, but there will be some for sure and they will be highlighted for you. However, there is a lot of stuff you can do right upfront

Is there still going to be a one-on-one with the CTO?

Definitely, it is very helpful, but this time please arrive with the COP completed, this allows for better interaction. It would also be nice to get them in advance because then you will get more feedback

20. Closure

Dr. John Crowley

Thanked everyone for the success over the last year. A special thanks to two staff members who have pushed the whole OVC agenda – Anita Sampson and Fatima Dos Santos. It is the second time we

have all gotten together. There are also a couple of new partners welcome. Last years focus was on what we were doing and what we had planned. This year there has been a real shift from getting to know one another to addressing some important themes. There are a number of themes and issue that we need to reflect on, digest and come up with some possible solutions. Issue on volunteers, Childcare workers how they relate to the expansion of public works issues. Issues over Childcare Forums and how they operate, the links between OVC and other PEPFAR programs, there is a tendency to make a distinction but they are not separate entities, they need to be pulled together. In prevention we have prevention messages but are they really linking with OVC. It is time to start thinking about making linkages, this doesn't mean you have to do it yourself but where is the player that can provide that service? There is a move to go beyond bead-making. There are opportunities for public-private partnerships that are done in treatment arena but so far have been lacking in the OVC arena. A trouble in all sectors of health is the balance between quality and reaching maximum number of people. Emphasis must be placed on communication, networking, talking, and writing. We must use all the means and resources at our disposal and also tell the stories. Sometimes we are so busy doing that we don't tell the stories. We haven't done it specifically for OVC, so asking to help do some communications at national level. It is important to continue dialogues and discussion amongst one another, on annual basis probably won't be enough, maybe we should think about setting up panels on different topics. Maybe we should set up forums to increase discussions in addition to or independently from the annual meetings. Thank you to all, we have made a huge jump, we are learning lots of new things. We hope to put something together with DSD focusing on issues rather than programs to be able to deal with these issues and find better ways to do things.